

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
To disclose health information in the medical records:

\_\_\_\_\_ BD: \_\_\_\_\_ SS#: \_\_\_\_\_  
(PRINT name of patient)

**Information to be sent to:**

\_\_\_\_\_  
Name of designated recipient  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State, Zip Code      \_\_\_\_\_  
Phone Number

**Information to be released:**

\_\_\_\_ Progress Notes      \_\_\_\_ EKG's      \_\_\_\_ Immunizations  
\_\_\_\_ Lab Reports      \_\_\_\_ Problem List      \_\_\_\_ Consultations  
\_\_\_\_ Radiology Reports      \_\_\_\_ Medication List      \_\_\_\_ Accounting of Disclosure  
\_\_\_\_ Other (please specify) \_\_\_\_\_  
\_\_\_\_ **All health care information**

Specify date(s) of treatment requested: \_\_\_\_\_

**Purpose for which disclosure is being made: (Please check one of the following)**

\_\_\_\_ Attorney      \_\_\_\_ Insurance      \_\_\_\_ Doctor      \_\_\_\_ Personal

**Patient Authorization:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

**EXCLUDE the following information from the records released (please initial)**

\_\_\_\_ Drug/Alcohol abuse/treatment & diagnosis      \_\_\_\_ Sexually Transmitted Infections  
\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_ Mental Illness

**My Rights**

I understand I don not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign the authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health information for a third party.

I may revoke the authorization in writing. To review the process for revoking the authorization, please read the Privacy Notice to our patients. I understand that once Yakima Medical Clinic discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(Patient, Guardian\*, or Authorized Representative\*)

**(Please provide documents to prove authority to sign on behalf of the patient)**

**This authorization will expire 90 days from the date signed. Possible copying fee required**

If you desire a copy of this authorization, please nifty a representative of the Medical Records department upon completion of this form.

